

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

05495

Reg. Dist. No.

5522

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carroll</b> Middle <b>C.</b> Last <b>Algard</b>				4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 16 1883</b>	
9. AGE (In years and birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.R. Trackman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Valentine B. Algard</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Bdna Mae Algard Charlestown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>240X</b> <b>Acute Myeloid Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 yrs</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteomyelitis Right Foot</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 18, 1958</b> to <b>May 6, 1959</b> , that I last saw the deceased alive on <b>May 6, 1959</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.				ADDRESS (Street, city or town, state) <b>Port Deposit Md.</b> DATE SIGNED <b>5/7/59</b>			
PHYSICIAN'S NAME (Type) <b>CLARENCE I. BENSON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Charlestown</b>		22d. LOCATION (City, town, or county) (State) <b>Charlestown, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

112

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5523

## CERTIFICATE OF DEATH

05496

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colore</u>		c. LENGTH OF STAY IN IB <u>2 5/8 (Rural) 2 mi. W of Rising Sun</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>CLARENCE B. BAUGHMAN</u>		4. DATE OF DEATH <u>May 12 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 2, 1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Builder</u>	
11. BIRTHPLACE (State or foreign country) <u>State of Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Baughman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Baughman, Colore Md</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-7943</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 1958</u> to <u>5/12 1959</u> that I last saw the deceased alive on <u>5/11 1959</u> and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Maryland</u> DATE SIGNED <u>5/13/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	22d. LOCATION (City, town, or county) (State) <u>Colore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed, Rising Sun, Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE MAY 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1910

*(Faint, mostly illegible handwritten text follows, likely containing name, date, and cause of death information.)*

1

*(Faint vertical text on the right margin, possibly a filing or archival note.)*



• *U.S. and Foreign Trade in 1995*

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2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818 2819 2820 2821 2822 2823 2824 2825 2826 2827 2828



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05498

5503

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk ton</b>			c. LENGTH OF STAY IN 1b <b>Life</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>			e. STREET ADDRESS <b>1</b>		
3. NAME OF DECEASED (Type or print) First <b>Linda</b> Middle <b>Susan</b> Last <b>Billings</b>			4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1954</b>		9. AGE (In years last birthday) <b>4</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Chester L. Billings, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Gertrude G. Seymour</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----			16. SOCIAL SECURITY NO. -----		
17. INFORMANT <b>Mrs. Gertrude Billings, Elkton, Md.</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Glomerulonephritis</b> <b>592x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>19 59</b> , to <b>20 May 19 59</b> , that I last saw the deceased alive on <b>19 May 19 59</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Clifton R. Brooks</b>			ADDRESS (Street, city or town, state) <b>269 E. Main Street Newark, Del.</b>		
PHYSICIAN'S NAME (Type) <b>Clifton R. Brooks</b>			DATE SIGNED <b>5/20/59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 22/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Cherry Hill, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks</b>			ADDRESS <b>Elkton, Md.</b>		
24a. REC'D BY REGISTRAR <b>MAY 27 59</b>			24b. REGISTRAR'S SIGNATURE <b>Clifton R. Brooks</b>		





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5525

## CERTIFICATE OF DEATH

Reg. Dist. No. 05499

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nottingham, R.D. 1</b>		c. LENGTH OF STAY IN 1b <b>10 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Graybeal Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>T</b> Last <b>BLACKSON</b>		4. DATE OF DEATH Month <b>5-8</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1876</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>All kinds work</b>	
11. BIRTHPLACE (State or foreign country) <b>Perryville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>AARON BLACKSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY ABHAM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-18-1975</b>	
17. INFORMANT <b>ADDRESS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1st</b> , 19 <b>59</b> , to <b>5-8-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-8-59</b> , 19 <b>59</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b> DATE SIGNED <b>5-9-59</b>			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		PHYSICIAN'S NAME (Type) <b>R.C. Dodson</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-11-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Principios</b>	22d. LOCATION (City, town, or county) (State) <b>Furnace, Cecil Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson + Son</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>	
ADDRESS <b>Perryville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Clifton L. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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270-1-1075

## 5526 CERTIFICATE OF DEATH

Reg. Dist. No. 96

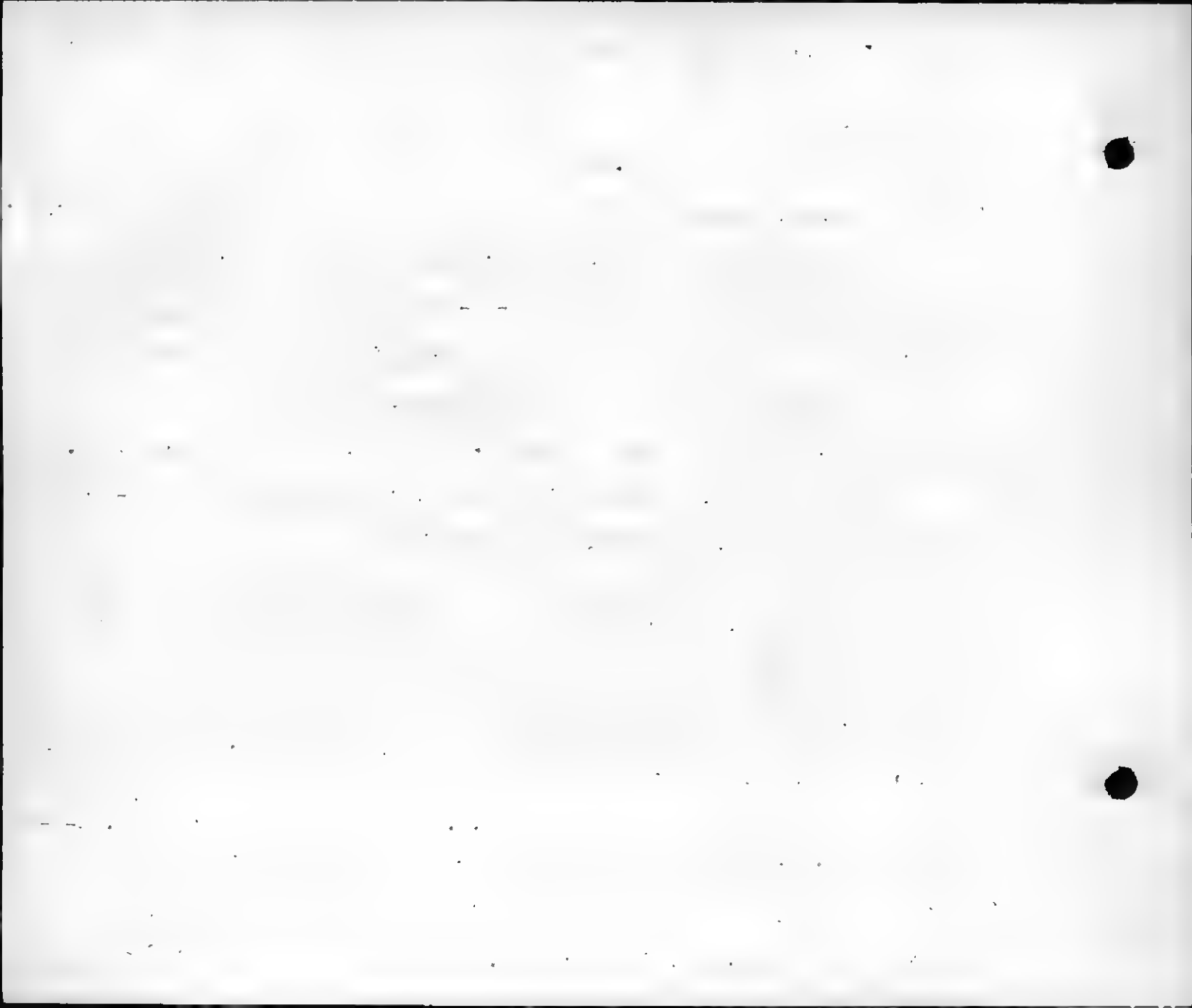
1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Wyoming</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cecil</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <b>Unknown</b>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>(NMI)</b> Last <b>BOGATAJ</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-24-94</b>
9. AGE (In years last birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>	
11. BIRTHPLACE (State or foreign country) <b>Jugoslavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral unresolved</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 28, 1943</b> , to <b>May 7, 1959</b> and that death occurred at <b>8:40 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>J. L. GAREY</b>		M.D. <b>V.A. Hospital, Perry Point, Md. 5-8-59</b>	
PHYSICIAN'S NAME (Type) <b>J. L. GAREY</b>		Clinical Pathologist	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>5/15/59</b>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		ADDRESS <b>Havre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05501

Reg. Dist. No.

5527

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) b. COUNTY <b>Del.</b> <b>Newcastle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.</b>		c. LENGTH OF STAY IN 1b <b>all life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark, &amp; Christiana</b>	
3. NAME OF DECEASED (Type or print) First <b>Franklin</b> Middle <b>Stanley</b> Last <b>Bryan</b>		4. DATE OF DEATH Month <b>5</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-23-1922</b>
9. AGE (In years last birthday) <b>37</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George S. Bryan</b>		14. MOTHER'S MAIDEN NAME <b>Helen Bullock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2 217-18-3759</b>	
17. INFORMANT <b>Mrs. Helen Bullock, Townsend, Del.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pistol bullet in center of Forehead</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot self after shooting wife</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Elkton, R.D. Cecil Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>5-14-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 17, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>North East Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>North East Cecil Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		ADDRESS <b>North East Md</b>	
24a. REC'D BY REGISTRAR <b>MAY 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

VS. A15ME(5)  
SM 9/55

5528

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05502

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harvy Wharf - North East		d. STREET ADDRESS 126 Market Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Berkley Butler		4. DATE OF DEATH Month Day Year May 24 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 19 30
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gen. Electric Co.	
11. BIRTHPLACE (State or foreign country) BALTO Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ALBERT C. BUTLER		14. MOTHER'S MAIDEN NAME MARY C. BUTLER Cecelia Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-24-3891	
17. INFORMANT Mrs. MARY Cecelia Hinkel		110 S. Culver St. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning 7298 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found floating in water	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. May 20 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River	
20f. (City or town) Rising Sun Cecil Maryland		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cem.		22d. LOCATION (City, town, or county) Balto. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE S. Freeman Schuch		24a. REC'D BY REGISTRAR DATE MAY 26 '59	
		24b. REGISTRAR'S SIGNATURE Charles E. Hines	

3512 Frederick Ave. (29)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

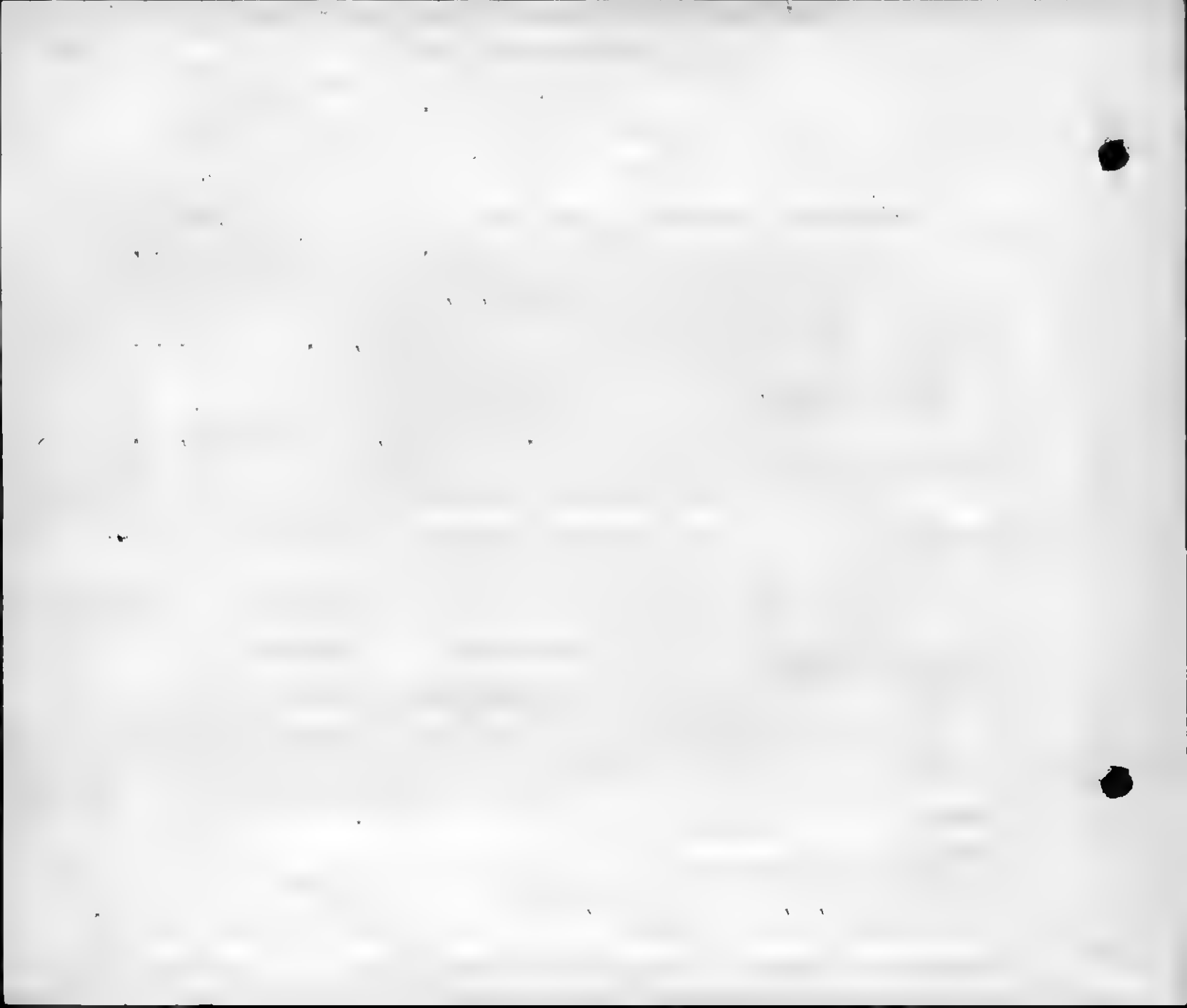
05503

5529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cecilton</b>		c. LENGTH OF STAY IN 1b <b>Rural Cecilton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>HENRY</b> Last <b>BYERLY Jr.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March, 27, 1889</b>
9. AGE (In years and birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Florist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Henry Byerly, I</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Gest</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>197-12-0690</b>	
17. INFORMANT <b>Mrs. Anna Byerly,</b>		Address <b>Cecilton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastatic urinary bladder carcinoma</b> DUE TO (c) <b>senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>7 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>senility</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. FL. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1954</b> , 19 <b>May 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 10</b> , 19 <b>59</b> , and that death occurred at <b>8:00a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b>	
DATE SIGNED <b>11 May 59</b>			
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May, 12, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington, Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows</b>		ADDRESS <b>Millington Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5504

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Newark	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 5 Phillips Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harry F. Cavender				4. DATE OF DEATH Month Day Year May 15, 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1881	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Cavender				14. MOTHER'S MAIDEN NAME Sadie Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT 5 Phillips Ave. Mrs. Florence M. Cavender Newark, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of gall bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cholelithiasis + Cholecystitis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 hours Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity + Gen Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-14, 1959, to 5-15, 1959, that I last saw the deceased alive on 5-14, 1959, and that death occurred at 6:55 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Williford Eppes M.D. 325 E. Main St 5-15-59 PHYSICIAN'S NAME (Type) Williford Eppes Newark Del							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.		22d. LOCATION (City, town, or county) (State) Bethel, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE K.T. Jones				ADDRESS Newark Del		24a. REC'D BY REGISTRAR DATE MAY 19 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Cholelithiasis & Cholecystitis  
 Repair of gall bladder 12-12-24

Copied & given to Arterio-sclerosis

2-12-24	Newark Del	352 E. Main St	2-12-24
2-14	Edison	352 E. Main St	2-14
2-14	Edison	352 E. Main St	2-14



## 5530 CERTIFICATE OF DEATH

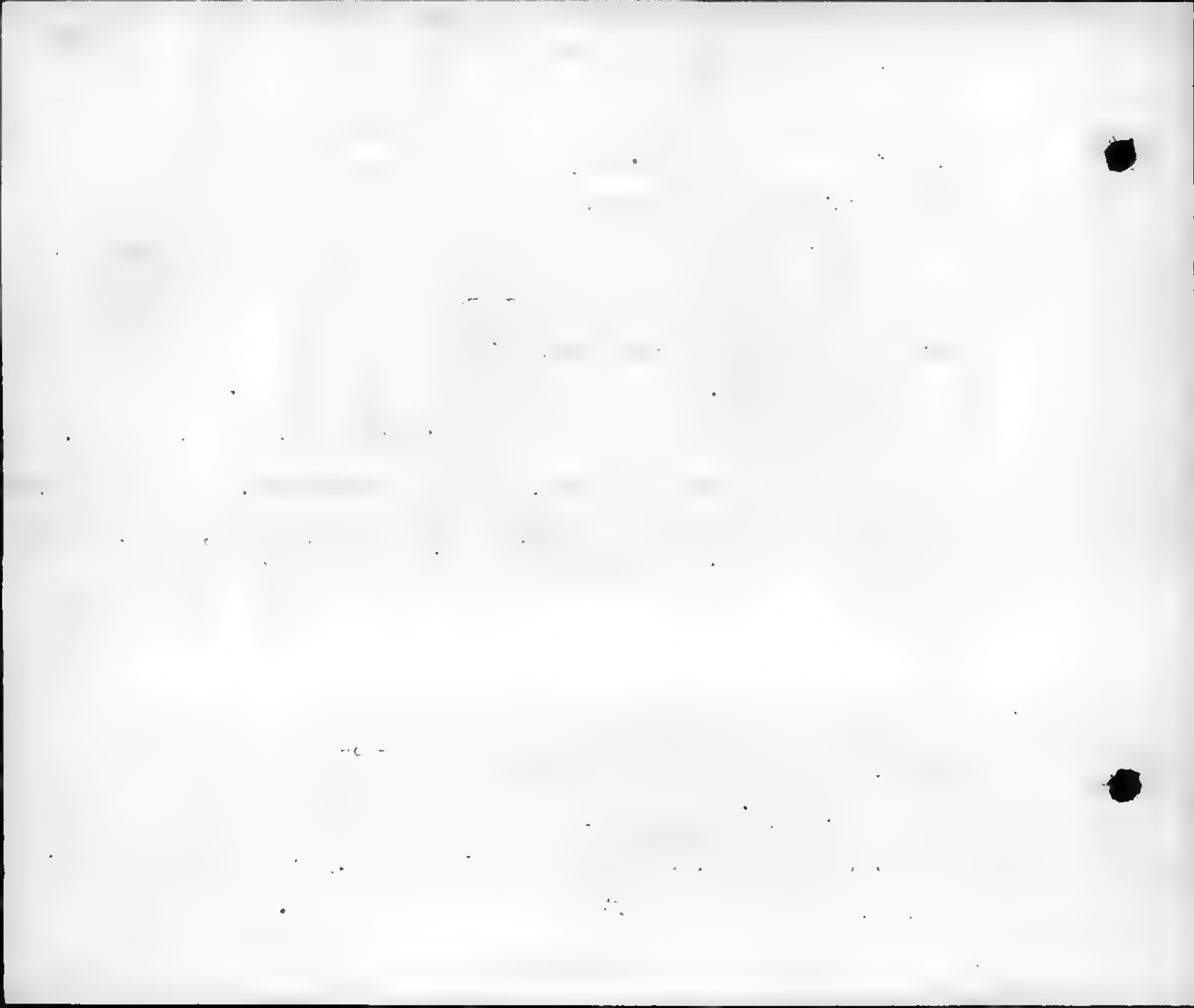
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN 1b <b>5 mo. 28 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b> d. STREET ADDRESS <b>?</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>CLARK</b> Middle Last 5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>6-17-1900</b> 9. AGE (In years last birthday) <b>58</b> yrs 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b> 11. BIRTHPLACE (State or foreign country) <b>Unknown</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		4. DATE OF DEATH Month <b>5</b> Day <b>26</b> Year <b>1959</b> 13. FATHER'S NAME <b>Michael Gilligen (Dec.)</b> 14. MOTHER'S MAIDEN NAME <b>Elizabeth Clark (Dec.)</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> 16. SOCIAL SECURITY NO. <b>None</b> INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL, UNRESOLVED.</b> 161X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GARCINOMA, RECURRENT, SITE OF LARYNGECTOMY,</b> DUE TO <b>WITH EROSION INTO THE LEFT CAROTID VESSEL</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Interval between onset and death <b>4 To 5 days</b> Unknown		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-31-34</b> , 19, to <b>5-26-</b> , 19 <b>59</b> and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>S. P. Lacerva</b> M.D. PHYSICIAN'S NAME (Type) <b>S. P. LACERVA, M.D.</b> ADDRESS <b>VA HOSPITAL, PERRY POINT, MARYLAND</b> 22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>REMOVAL</b> 22b. DATE THEREOF <b>6/1/59</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Md.</b> 22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>Harold H. Hays, Md.</b> ADDRESS <b>Baltimore, Md.</b> 24a. REC'D BY REGISTRAR <b>JUN 3 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hays</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5505

## CERTIFICATE OF DEATH

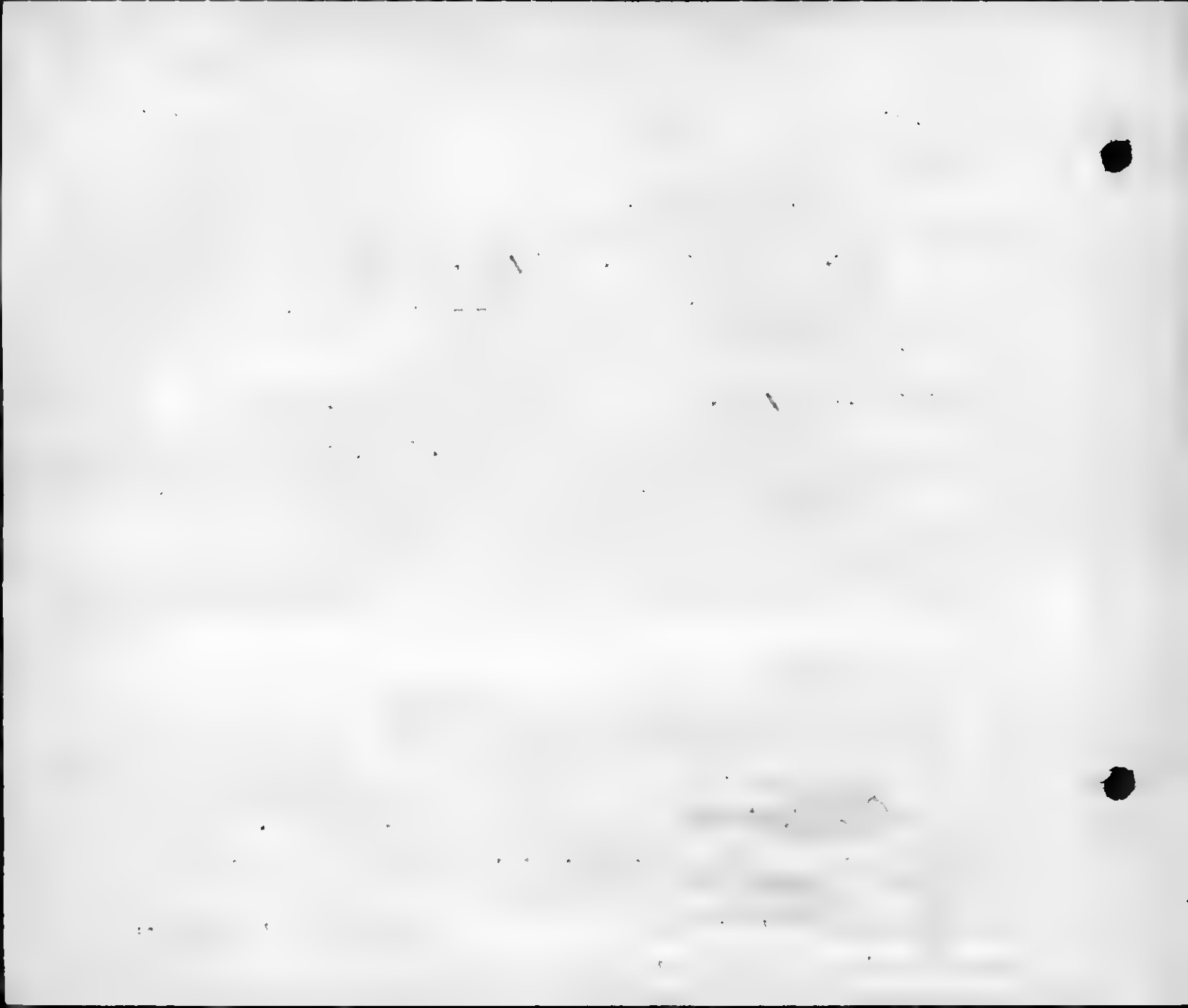
05506

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Devine Haven Nursing Home</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u> d. STREET ADDRESS _____			
<b>3 NAME OF DECEASED</b> (Type or print) First <u>Dr. Clarence</u> Middle <u>B.</u> Last <u>Collings Jr.</u>				<b>4 DATE OF DEATH</b> Month <u>May</u> Day <u>29</u> Year <u>1959</u>			
<b>5 SEX</b> <u>Male</u>		<b>6 COLOR OR RACE</b> <u>white</u>		<b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8 DATE OF BIRTH</b> <u>12-4-1885</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9 AGE</b> (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <u>TEXAS</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>Clarence B. Collings Sr.</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise N. Miller</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____			
<b>16. SOCIAL SECURITY NO.</b> <u>none</u>				<b>17. INFORMANT</b> <u>Louise C. Hitch Jacksonville Florida</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1</u> <u>arteriosclerotic cardiovascular disease</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____	
<b>20f. (City or town)</b> _____ (County) _____ (State) _____				<b>21. I certify that I attended the deceased from</b> <u>October 6, 1956</u> , to <u>May 29, 1959</u> , that I last saw the deceased alive on <u>May 28, 1959</u> , and that death occurred at <u>8:06a.m.</u> from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>[Signature]</u> M.D. <u>233 S. Main St.</u>				<b>DATE SIGNED</b> <u>May 29, 1959</u>			
<b>PHYSICIAN'S NAME (Type)</b> <u>S. Paul Anderson, Jr., M.D.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>June 1, 1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Methodist</u>		<b>22d. LOCATION (City, town, or county)</b> <u>North East, Cecil Co., Md</u> (State) _____	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph R. Grant</u> ADDRESS <u>North East, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> DATE <u>JUN 3 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

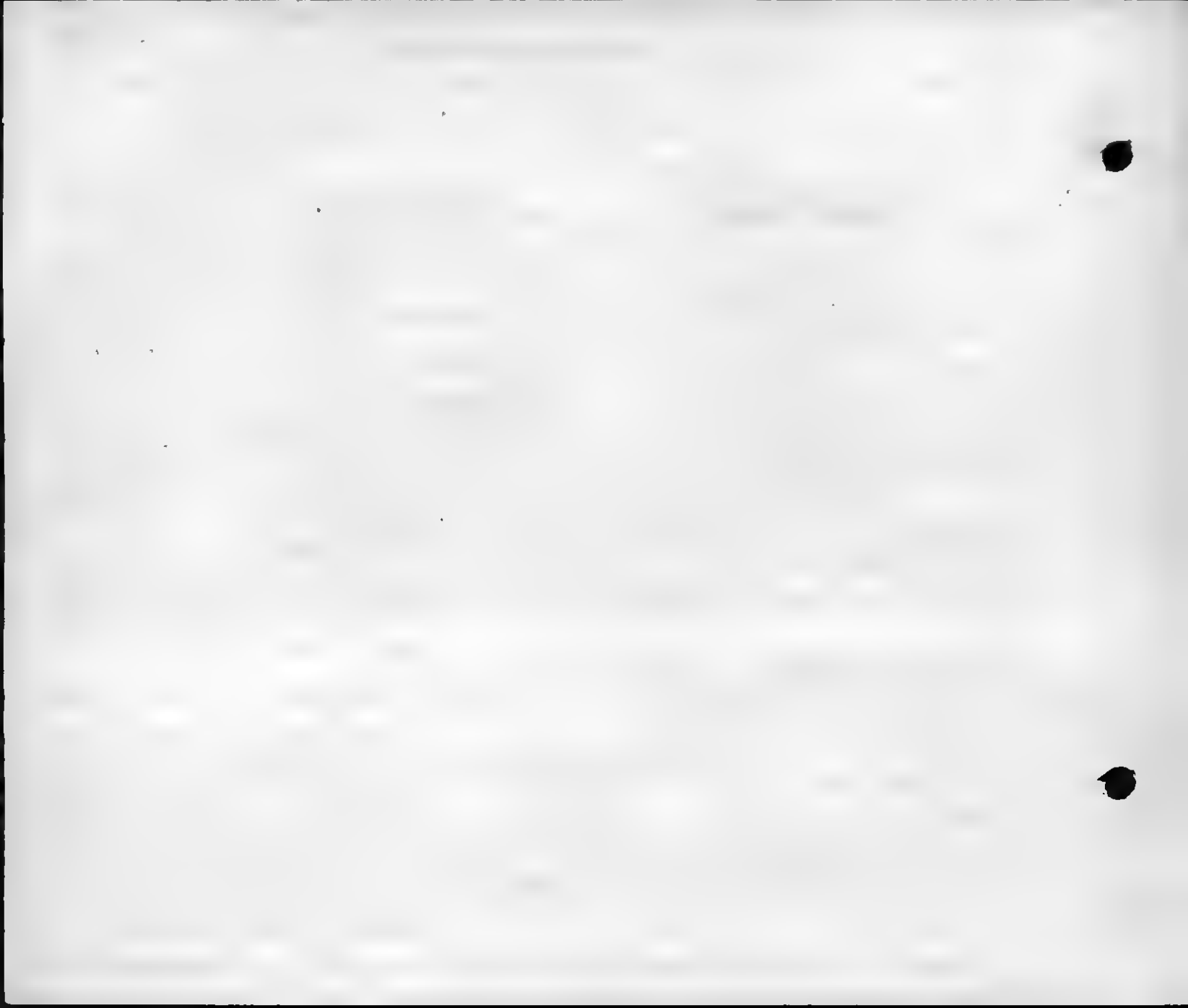
## CERTIFICATE OF DEATH

05508

Reg. Dist. No.

5506

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 140 W. ... Union Hosp.			
3. NAME OF DECEASED (Type or print) JO ANN Middle Last Dunlap				4. DATE OF DEATH May 23, 1959			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1959	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Day Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Carroll M. Dunlap				14. MOTHER'S MAIDEN NAME Katherine Simpers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father		Address Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Premature DUE TO (b) Possible Poisoning & Struck Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) -----						INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 May, 1959, to 23 May, 1959, that I last saw the deceased alive on 23 May, 1959, and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Kreis		M.D.		ADDRESS (Street, city or town, state) Elkton, Md.		DATE SIGNED 5/25/59	
PHYSICIAN'S NAME (Type) George J. Kreis							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/1959		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Donald M. De		24a. REC'D BY REGISTRAR DATE JUN 1 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05509

Reg. Dist. No.

5531

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>			c. LENGTH OF STAY IN lb <b>all life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Aiken Ave</b>				d. STREET ADDRESS <b>Aiken Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>C</b> Last <b>Edwards</b>				4. DATE OF DEATH Month <b>5</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-20-1899</b>		9. AGE (in years last birthday) <b>59</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Perryville Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ward</b>				14. MOTHER'S MAIDEN NAME <b>Mary Chamberlain</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-30-5674</b>		17. INFORMANT <b>Nancy Edwards, Perryville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>4-20-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>5-8-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Principio Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Principio Furnace, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.C. Dodson</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 11 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5507

## CERTIFICATE OF DEATH

Reg. Dist. No.

05510

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELKTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>	
c. LENGTH OF STAY IN b. <b>10 Days</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>UNION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Thomas Leroy Foard</b>		4. DATE OF DEATH <b>May 11 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/21/1888</b>
9. AGE (In years last birthday) <b>70 yrs</b>		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store-keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sales</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas J. Foard</b>		14. MOTHER'S MAIDEN NAME <b>Eva Cummings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs. Myrtle V. Foard</b>		Address <b>Ches. City, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma of Prostate</b> DUE TO (c) <b>3 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Seribility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 9, 1959</b> to <b>May 11, 1959</b> , that I lost s/he the deceased on <b>May 11, 1959</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>12 May 59</b>	
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/14/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Chesapeake City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b> ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 14 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Knead</b>			



5532

## CERTIFICATE OF DEATH

Reg. Dist. No.

05512

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural - Calvert md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Nottingham Pa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>R 10 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>D</u> Last <u>Gwaltney</u>		4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Rushy, Mason Co Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Reedy</u>		14. MOTHER'S MAIDEN NAME <u>Jane Shelton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Viola Gwaltney, Nottingham P. I. Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arthritis deformans</u> <u>723.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>May 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>59</u> , and that death occurred at <u>9 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>F. B. Robinson</u> M.D. <u>May 2 1959</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>May 4 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Oxford Cem.</u>		<u>Oxford, Chester Co Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M. Reed, Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 5508 CERTIFICATE OF DEATH

05511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle Last <b>GREEN</b>		4. DATE OF DEATH Month <b>May</b> Day <b>13</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May, 13, 1900</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Green</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-26-6403A</b>	
17. INFORMANT <b>Mrs. Mary E. Husfelt,</b>		Address <b>Earleville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cerebral arteriosclerosis</b> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>13 May</b> , 19 <b>59</b> to <b>13 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>13 May</b> , 19 <b>59</b> , and that death occurred at <b>4:30 p.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b> DATE SIGNED <b>16 May 59</b>	
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 17, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Sudlersville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward G. Holloway, Millington, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 20 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

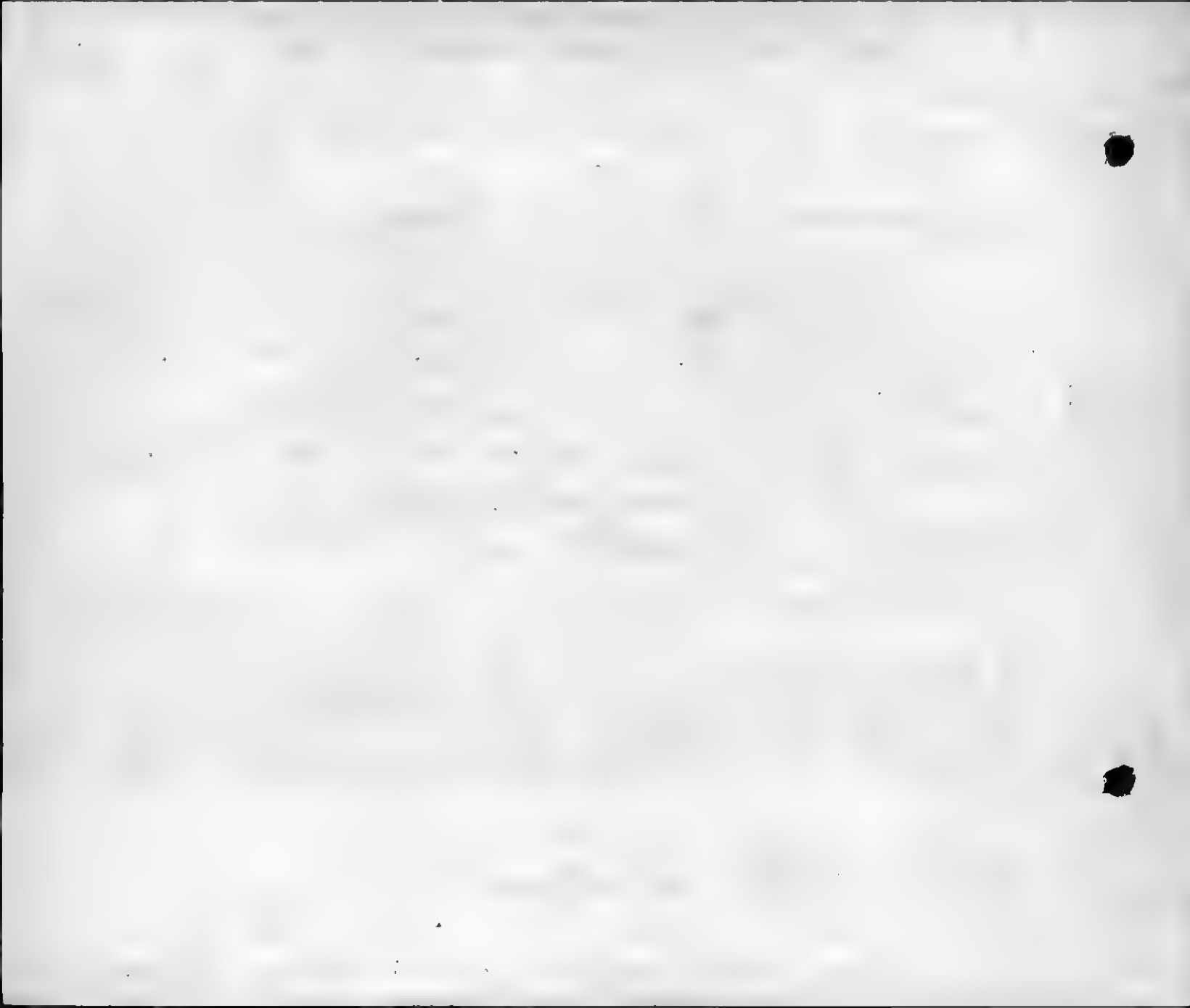
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5509

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05513

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE N. Y. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York 69X-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Union Hospital		d. STREET ADDRESS Sullivan St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KITTY HOLLAND		4. DATE OF DEATH Month 5 Day 17 Year 19 59	
5. SEX F.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harris Marcus		14. MOTHER'S MAIDEN NAME Fannie Marcus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Evelyn Greenburg		Address Kerhounkson, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion X DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetes (c) DUE TO stalling the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/17/ 1959	
22c. NAME OF CEMETERY OR CREMATORY Wellwood Cemetery		22d. LOCATION (City, town, or county) (State) Pinelawn, N. Y.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE MAY 21 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



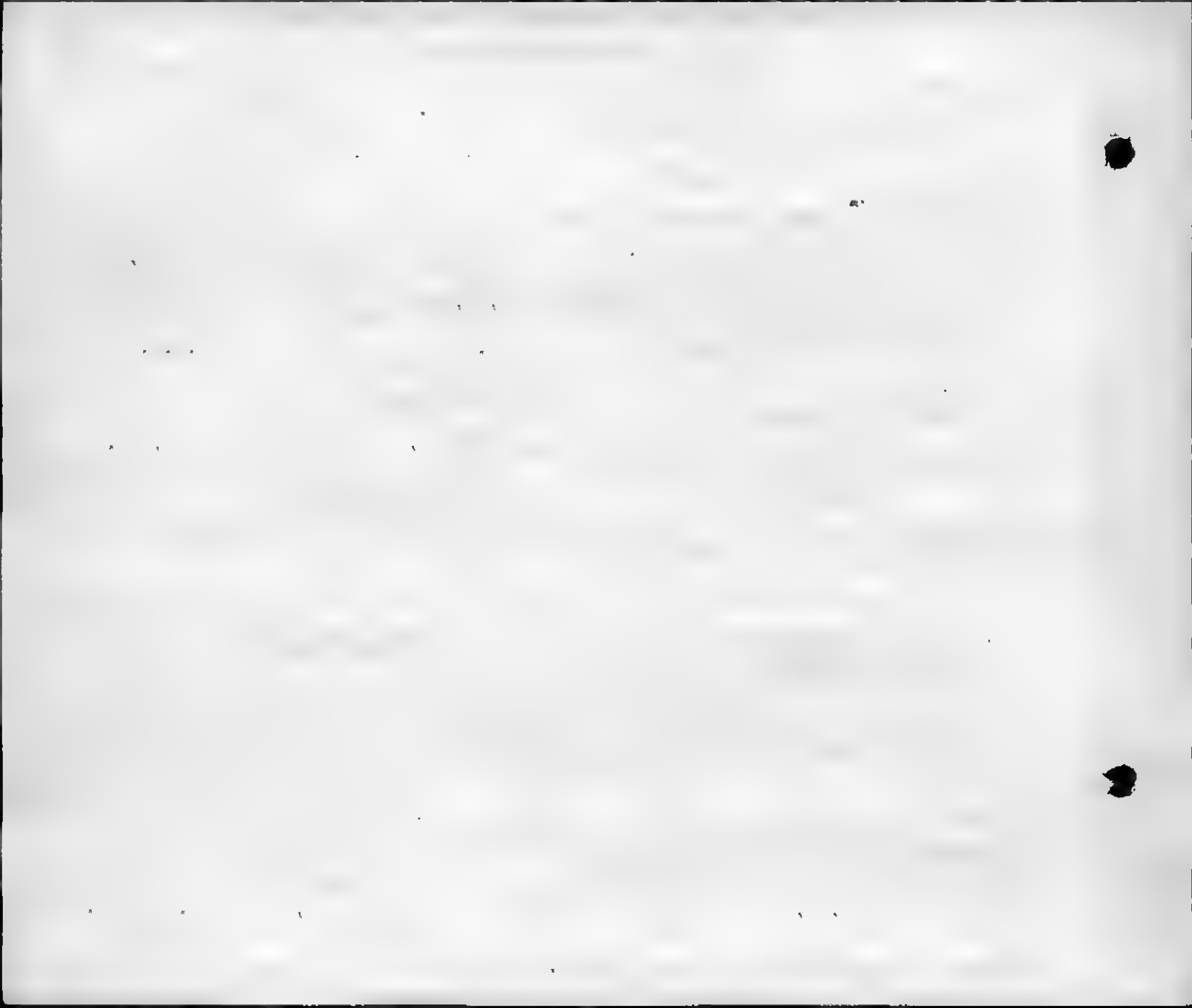
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5510 CERTIFICATE OF DEATH

Reg. Dist. No. 05514

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Earleville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>E.</b> Last <b>HUSFELT</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June, 13, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Davis</b>		14. MOTHER'S MAIDEN NAME <b>Laura Biggs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Frank Husfelt,</b>		Address <b>Earleville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardio-vascular Disease</b> DUE TO (c) <b>x years</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute mesenteric Thrombosis - 12 hours before death</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. n.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>54</b> , to <b>May 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>59</b> , and that death occurred at <b>7:00</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace O'Brien</b>		ADDRESS (Street, city or town, state) <b>Cecilton, Md.</b>	
DATE SIGNED <b>25 May 59</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM O'BENSHAW</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May, 26, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cecilton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cecilton, Cecil Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Sellers</b>		ADDRESS <b>Wilmington, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAY 28 59</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



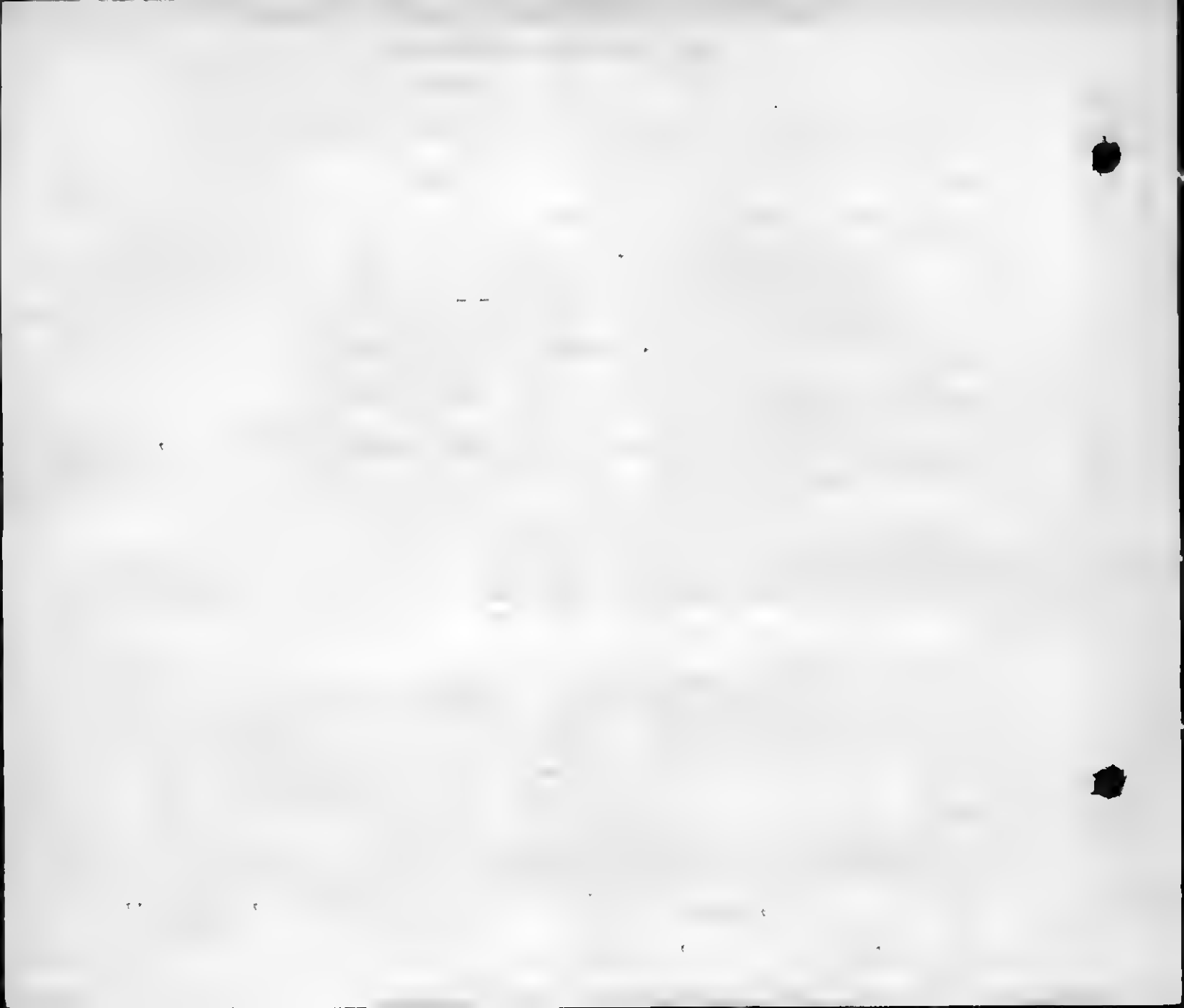
## 5533 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>James G. Jones</b>				4. DATE OF DEATH Month Day Year <b>May 26 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-2-1880</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gardner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Veg. Raising</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>							
13. FATHER'S NAME <b>Samuel Jones</b>				14. MOTHER'S MAIDEN NAME <b>Berna Priest</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs Ernest Demond North East, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>15 years</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 26</b> , 19 <b>59</b> , to <b>26 May</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>26 May</b> , 19 <b>59</b> , and that death occurred at <b>8 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>North East, Md</b> DATE SIGNED <b>27 May 1959</b> ACTUAL SIGNATURE <b>James H. Jones</b> M.D. <b>North East, Md</b> PHYSICIAN'S NAME (Type) <b>James H. Jones M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 29, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>North East, Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>North East, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Farris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

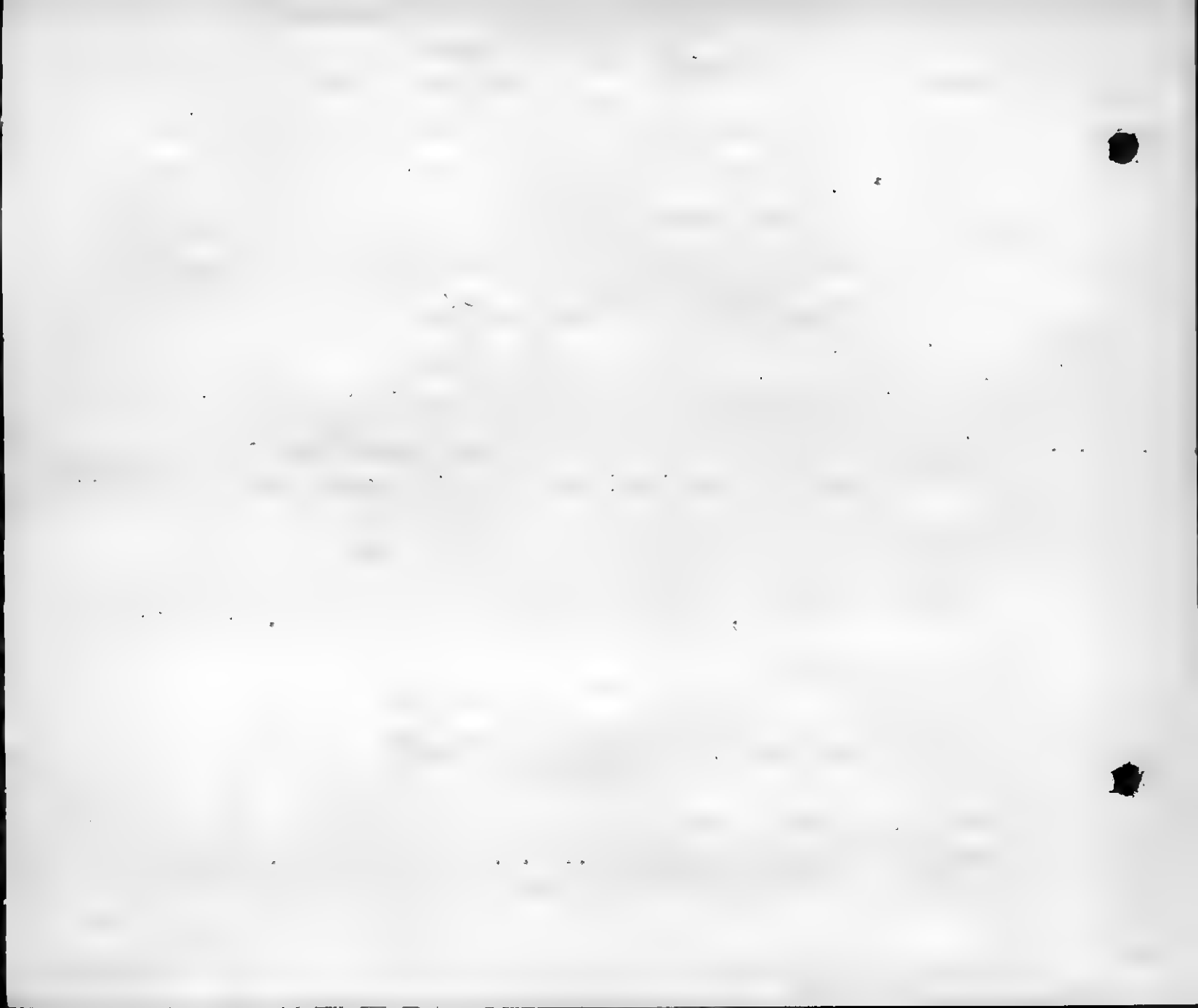
Item 1 Film G242 5-18-59 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

05516

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> 14X-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ELKTON Union Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>E.</u> Last <u>Kelley</u>		4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Anna Crowley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virginia Warner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Profound anemia, cause undetermined; generalized arthritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>59</u> , to <u>May 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 7</u> , 19 <u>59</u> , and that death occurred at <u>6:23 p. m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>May 7, 1959</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>5/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall</u> <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Loom</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '59</u>	
ADDRESS <u>Elkton Hall</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

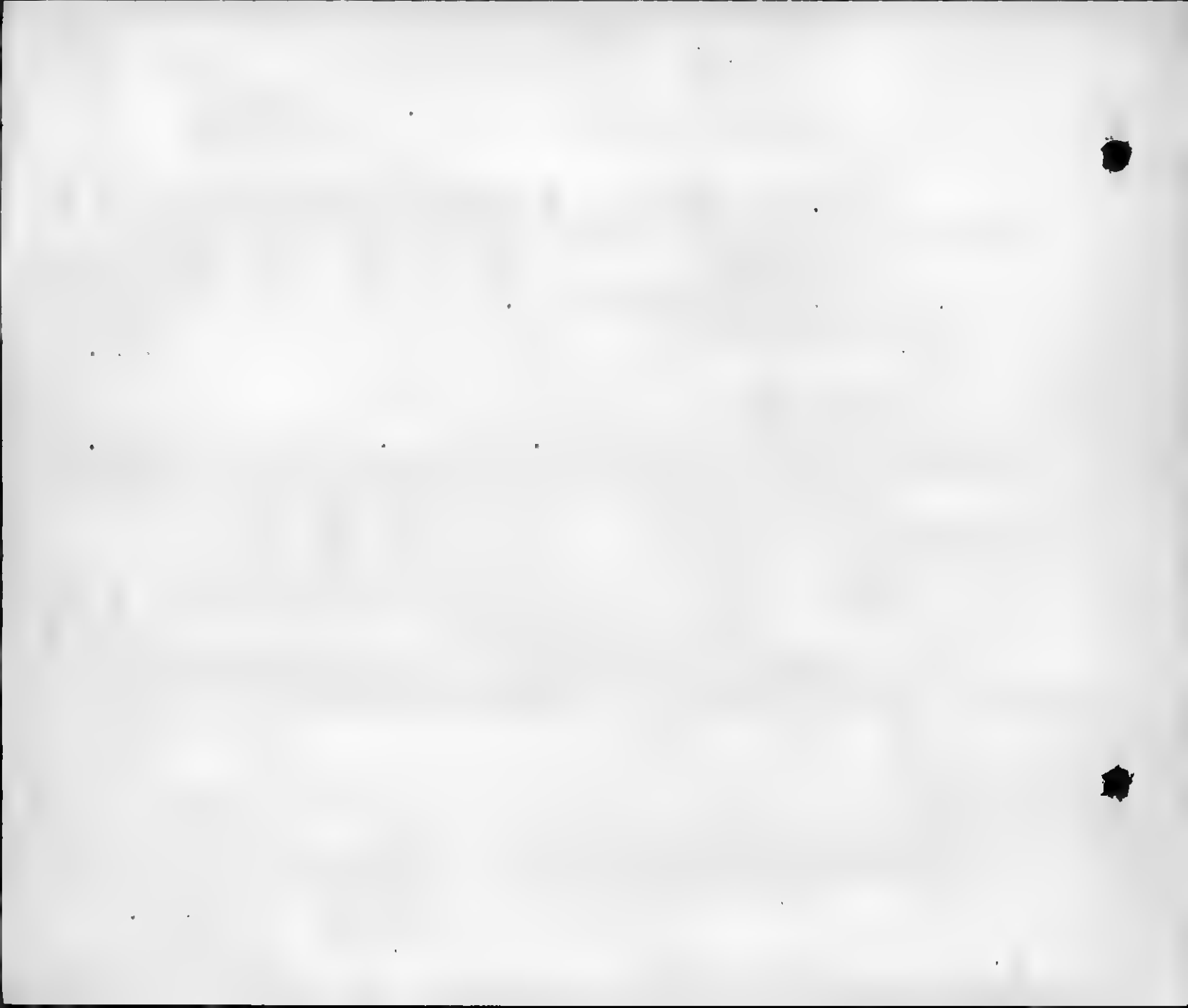
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5512 CERTIFICATE OF DEATH

Reg. Dist. No.

05517

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>317 W. Main Street</b>				d. STREET ADDRESS <b>317 W. Main Street</b>			
3. NAME OF DECEASED (Type or print) <b>Katie</b> First <b>Marcus</b> Last				4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1885</b>		9. AGE (In years lost birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Bullen</b>				14. MOTHER'S MAIDEN NAME <b>Ida Woodrow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. William H. Marcus</b> Address <b>Elkside, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Myocardial Infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic; Coroner's report</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 25, 1953</b> to <b>May 28, 1959</b> , that I last saw the deceased alive on <b>May 25, 1959</b> , and that death occurred at <b>7:15</b> M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>135 W. Main, Elkton, Md.</b> DATE SIGNED <b>June 26, 1959</b>							
ACTUAL SIGNATURE <b>Milford H. Sprecher</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Milford H. Sprecher</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/28/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. PIPPIN FUNERAL HOME</b>				ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 1 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5513 CERTIFICATE OF DEATH

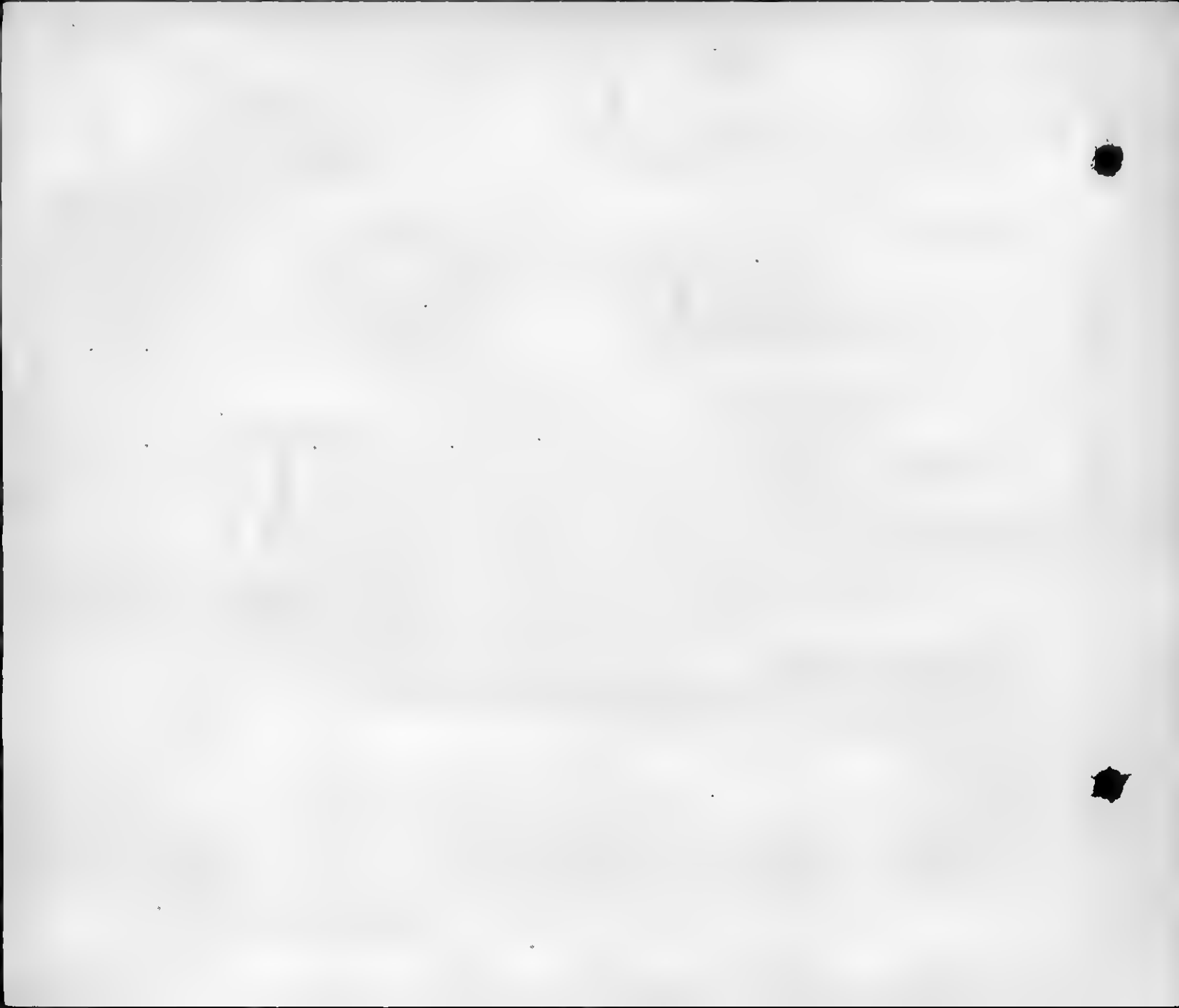
05518

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last I. Day McCauley				4. DATE OF DEATH Month Day Year May 12, 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1877	
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent				10b. KIND OF BUSINESS OR INDUSTRY Insurance			
13. FATHER'S NAME James T. McCauley				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No				16. SOCIAL SECURITY NO 217-03-5519		17. INFORMANT Address David R. McCauley, Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Colon with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) — 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from March 1955, to May 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Klaus H. Huebner M.D. North East, Md. May 12, 1959 PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER 22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 22b. DATE THEREOF 5/15/59 22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery 22d. LOCATION (City, town, or county) (State) Cherry Hill, Md. 23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Elkton, Md. 24a. REC'D BY REGISTRAR DATE MAY 20 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Knous							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 5534 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton R.D.3</b>		c. LENGTH OF STAY IN 1b <b>all life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nora</b> First <b>B.</b> Middle <b>Mendenhall</b> Last		4. DATE OF DEATH <b>5</b> Month <b>27</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>-1-5-1874</b>
9. AGE (In years lost birthday) <b>85</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph B. Yerkes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Erwin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. James F. Allen, Carrcroft, W.I. Del.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>4.2.2.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis extreme and nephritis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1956</b> , 19 <b>5-18-59</b> , that I last saw the deceased alive on <b>5-18-59</b> , 12 <b>6</b> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		DATE SIGNED <b>5-28-59</b>	
PHYSICIAN'S NAME (Type) <b>R.C. Dodson, M.D.</b>		ADDRESS (Street, city or town, state) <b>Rising Sun, Md.</b>	
22a. BURIAL, CREMATION, REINTERMENT <b>Burial</b>	22b. DATE THEREOF <b>5-31-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rosebank</b>	22d. LOCATION (City, town, or county) (State) <b>Calvert Cecil, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks</b>		ADDRESS <b>Elkton, Md.</b>	
24a. REC'D BY REGISTRAR <b>Arthur S. Hines</b>		DATE <b>JUN 4 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

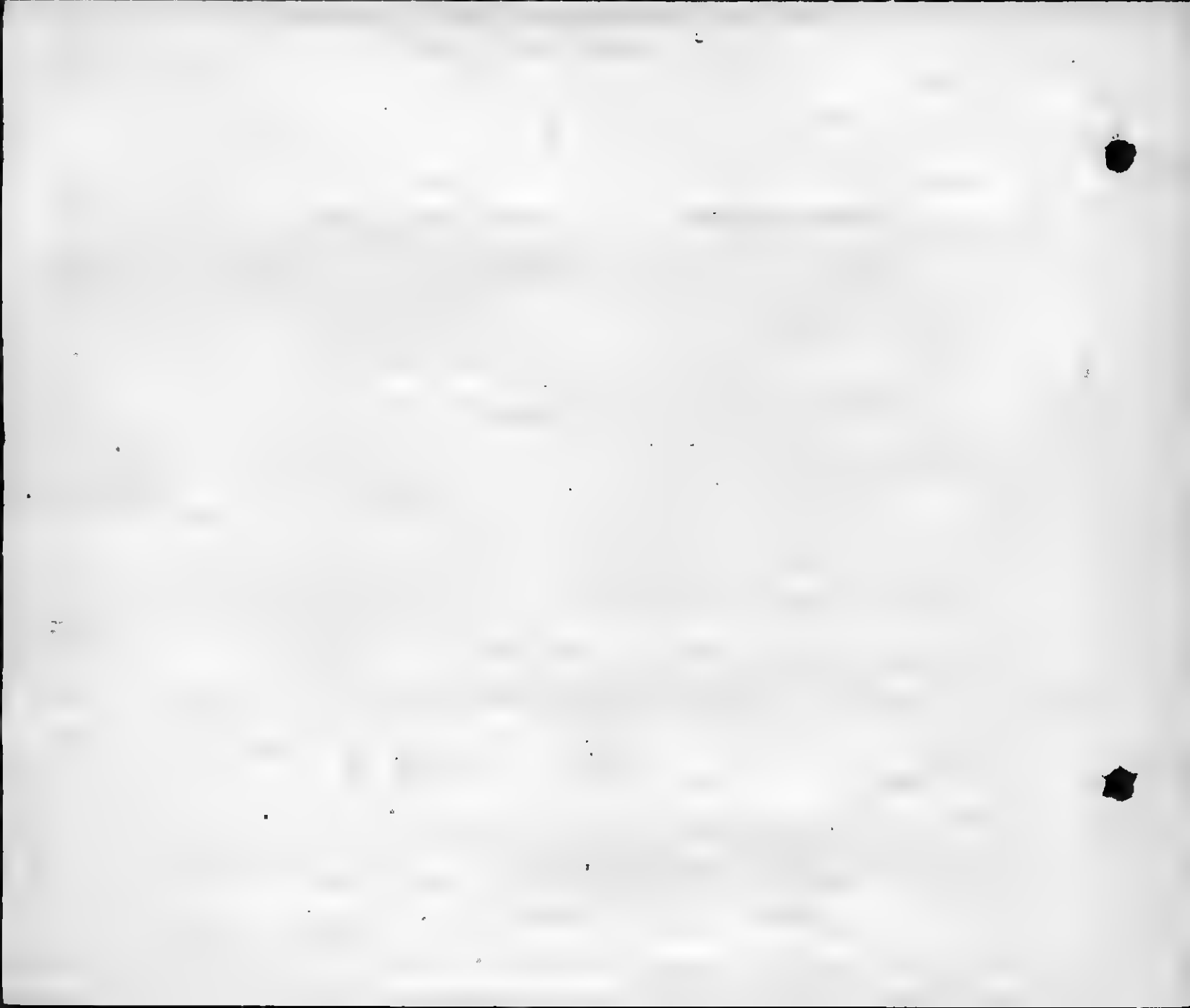
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5514 CERTIFICATE OF DEATH

Reg. Dist. No. 05520

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 1 Month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton			
3. NAME OF DECEASED (Type or print) ANNA First MAY Middle MENGES Last				4. DATE OF DEATH May 30 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1898		9. AGE (In years lost birthday) 60 yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail		10b. KIND OF BUSINESS OR INDUSTRY Sales		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William R. Heavellow				14. MOTHER'S MAIDEN NAME Daisey Money			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 222-01-8083		17. INFORMANT William R. Edmanson Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Clear cell carcinoma of renal origin 180x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH about 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 28, 1959 to May 30, 1959 that I last saw the deceased alive on May 30, 1959, and that death occurred at 3:20 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) 233 E. Main St.		DATE SIGNED May 30, 1959	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/1959		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS 1000 E. Elkton, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
				DATE JUN 4 '59			




# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5535 · CERTIFICATE OF DEATH

Reg. Dist. No.

05521  
96

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MARYLAND</b> Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 51 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, d. STREET ADDRESS 3607 Longfellow St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last BERT P. MEYEN				<b>4. DATE OF DEATH</b> Month Day Year May 9 1959											
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> Oct. 4, 1894		<b>9. AGE</b> (In years last birthday) 64 yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min		<b>11. IF UNDER 24 HRS</b> Months Days Hours Min			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Guard				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Unknown				<b>11. BIRTHPLACE</b> (State or foreign country) Omaha, Nebraska				<b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.			
<b>13. FATHER'S NAME</b> Paul Meyen				<b>14. MOTHER'S MAIDEN NAME</b> Pauline Schwag											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWI				<b>16. SOCIAL SECURITY NO.</b> Unknown				<b>INFORMANT</b> Hospital Records, VAH, Perry Point, Md.				<b>Address</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia, left lung</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> 3 days Unk.			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Carcinoma right lung, removal 4-17-59</b>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>March 19, 1959, to May 9, 1959</u> , <del>from the time of death to the time of death</del> , and that death occurred at <u>2:40 PM</u> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b>															
<b>ACTUAL SIGNATURE</b>  <b>PHYSICIAN'S NAME (Type)</b> <b>J. L. GAREY</b>				<b>M.D.</b> <b>V. A. Hospital, Perry Point, Md.</b>				<b>5-10-59</b>				<b>Clinical Pathologist</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) REMOVAL				<b>22b. DATE THEREOF</b> 5/15/59				<b>22c. NAME OF CEMETERY OR CREMATORY</b> Arlington National				<b>22d. LOCATION</b> (City, town, or county) (State) Ft. Myer, Virginia.			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>PENNINGTON &amp; SONS</b> , Havre de Grace, Md.								<b>24a. REC'D BY REGISTRAR</b> DATE <b>MAY 20 '59</b>				<b>24b. REGISTRAR'S SIGNATURE</b> Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

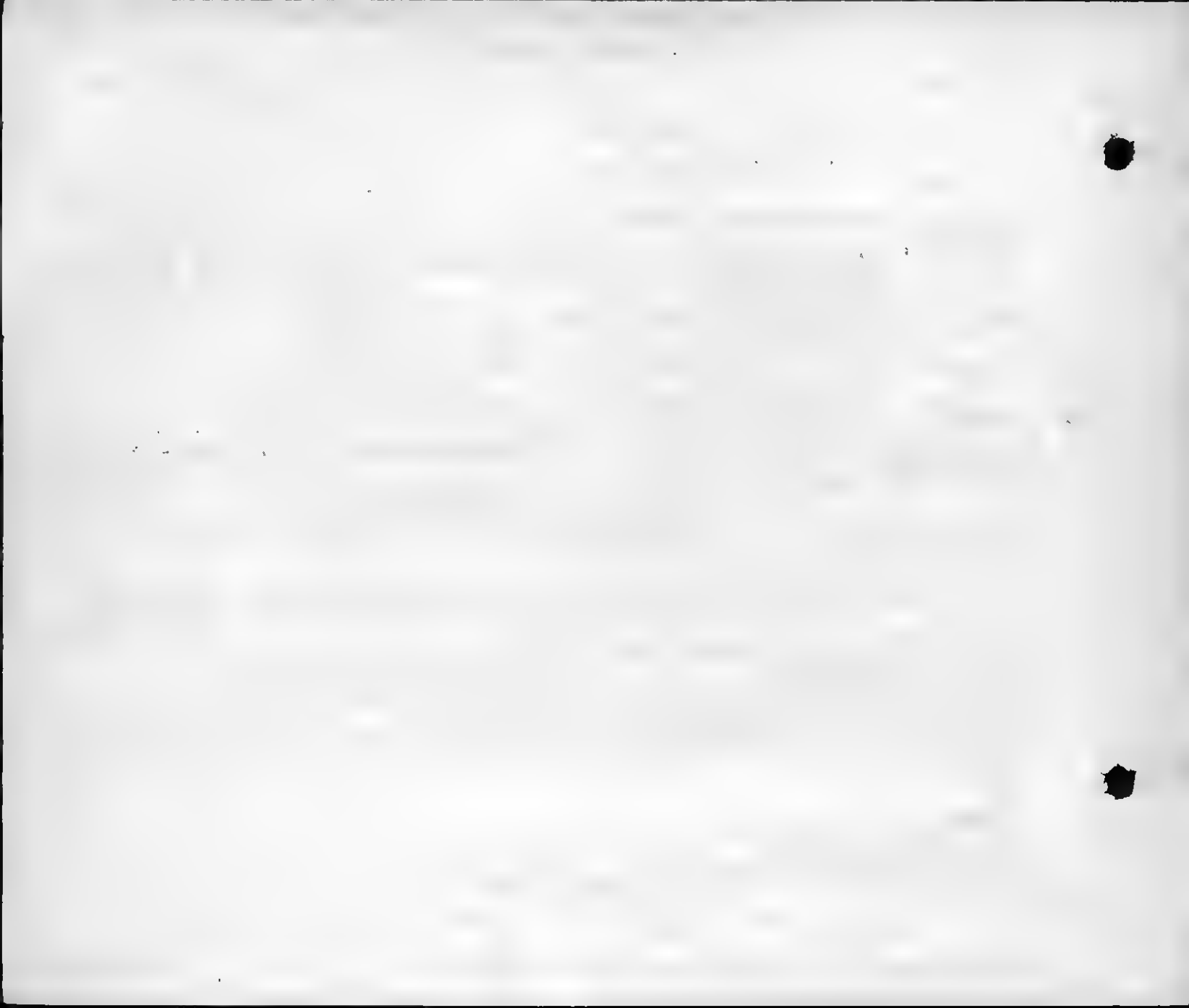
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5515 CERTIFICATE OF DEATH

05522

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>NEW CASTLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EIKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>18 AUGUSTA RD CHESTNUT HILL</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>-</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>5-</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILWORKER</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>FIBRE</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>-</u>	
14. MOTHER'S MAIDEN NAME <u>MARY VOSHELL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>222-07-8207</u>		17. INFORMANT <u>Richard Cikum - 18 Augusta Rd Newark Delaware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) <u>Unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-21</u> , 19 <u>59</u> , to <u>5-21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-21</u> , 19 <u>59</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>325 E Main Street Newark, Delaware</u> DATE SIGNED <u>5-21-59</u>			
ACTUAL SIGNATURE <u>Williford Eppes</u> M.D.		PHYSICIAN'S NAME (Type) <u>Williford Eppes</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-24-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEWARK METHODIST</u>	22d. LOCATION (City, town, or county) (State) <u>NEWARK Dela.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Narwick</u> ADDRESS <u>NEWARK Dela</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 25 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

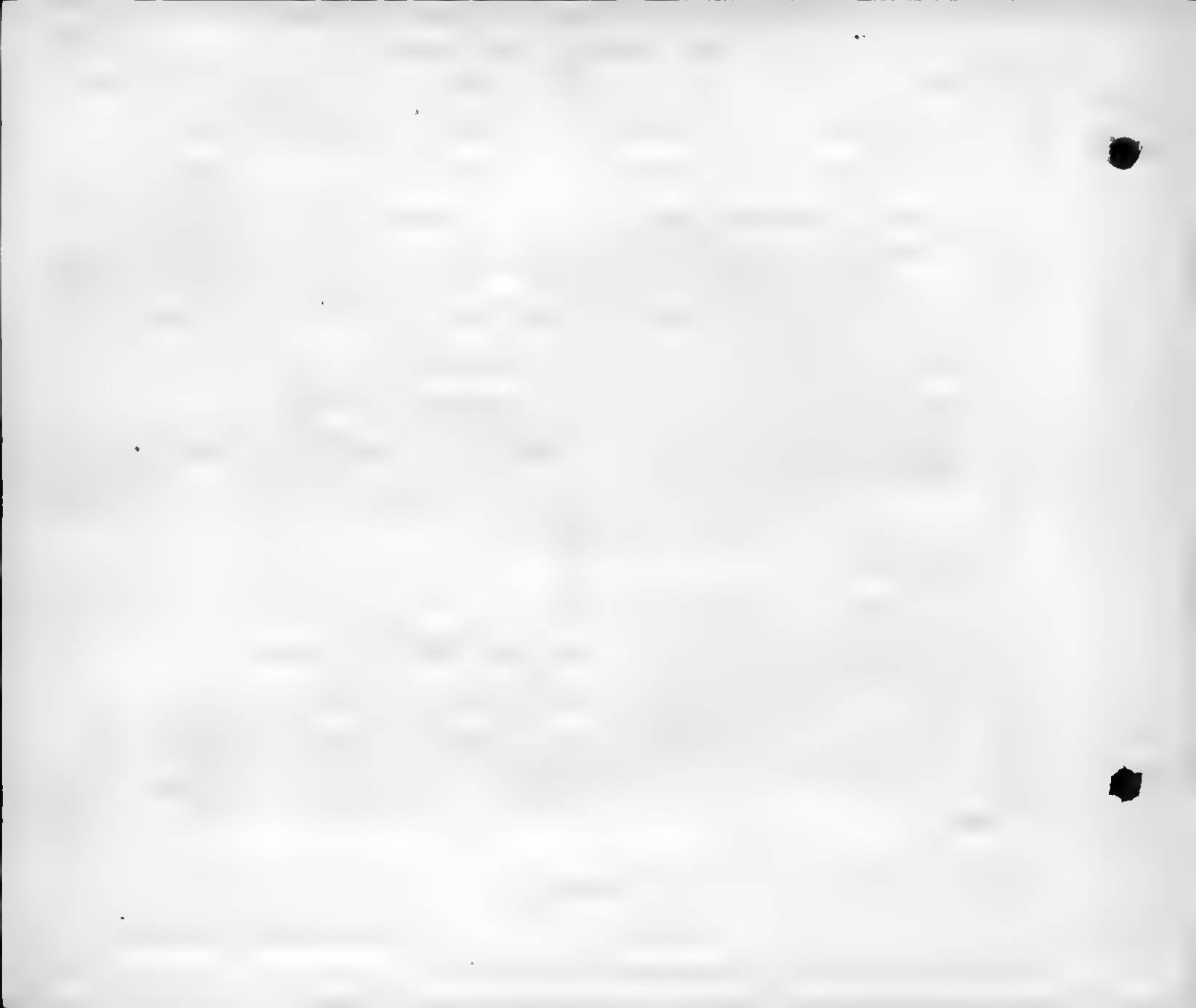
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5516 CERTIFICATE OF DEATH

Reg. Dist. No.

05523

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Rodney Purner		4. DATE OF DEATH Month Day Year May 11 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1959
9. AGE (In years lost birthday) --- yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Rodney Purner		14. MOTHER'S MAIDEN NAME Rachel Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address Chesapeake City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis + Pneumonia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 2, 1959, to May 11, 1959, that I last saw the deceased alive on 11 May, 1959, and that death occurred at 9:03 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Obenshain M.D.		ADDRESS (Street, city or town, state) Cecilton, Md.	
DATE SIGNED 11 May 59			
PHYSICIAN'S NAME (Type) Wallace Obenshain			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/13/1959	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS PIPPIN FUNERAL HOME 216 N. 1st St. Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAY 14 59	24b. REGISTRAR'S SIGNATURE Arthur L. Priddy





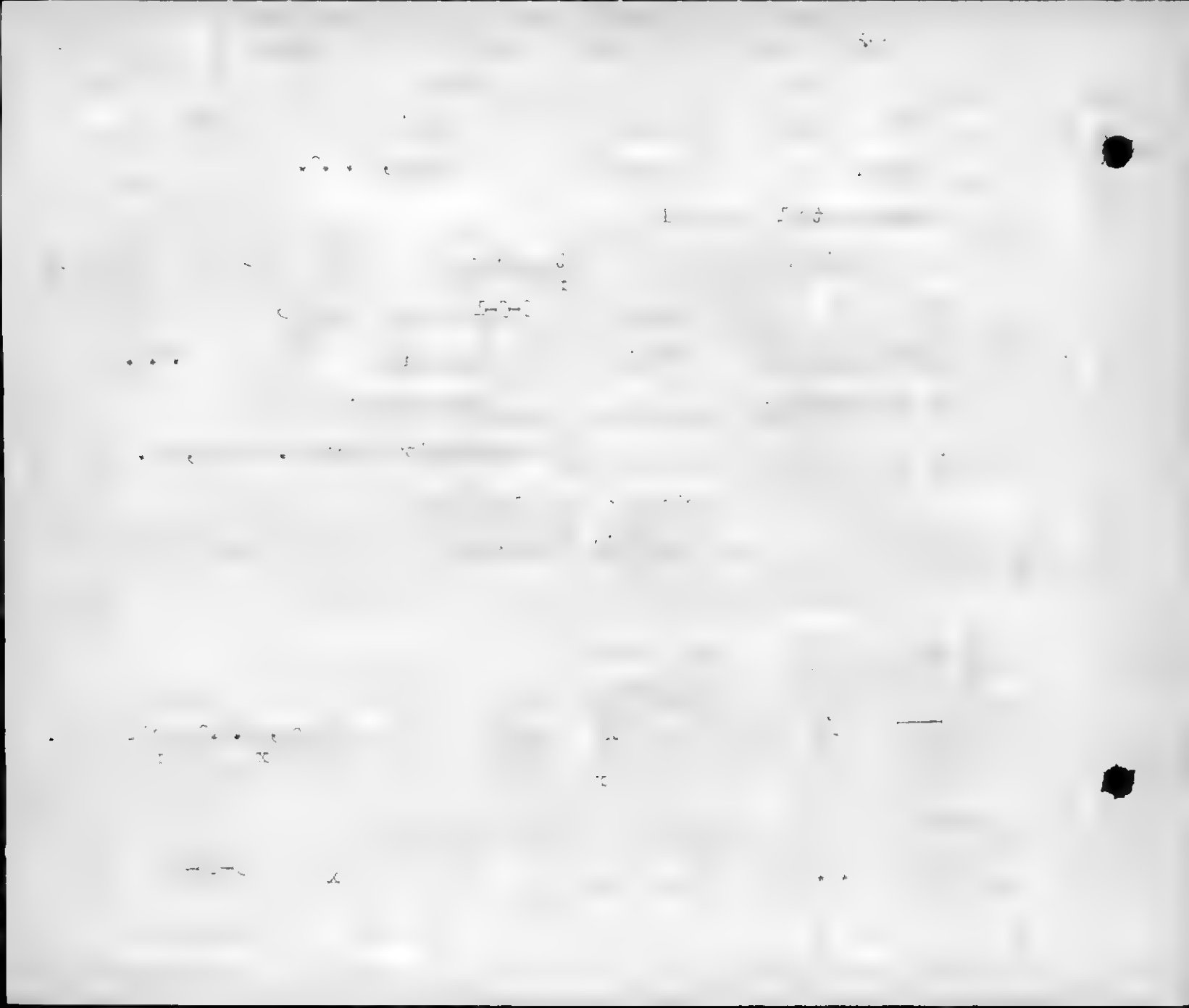
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 DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5517 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05524

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>Elkton, R.D.3.</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie Rattenbury</u>		4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-3-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>17</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired T. Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Rattenbury</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Ewing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Union Hospital Records, Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured of neck left femur</u> DUE TO (b) <u>Hypostatic Pneumonia</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in her home</u>	
20c. TIME OF INJURY Month, Day, Year <u>11 59 59</u> p. m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20e. (City or town) <u>Elkton, R.D.3 Cecil Md.</u>		20f. (County) <u>Cecil</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-20-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MARY ANN EPISCOPAL</u>		22d. LOCATION (City, town, or county) <u>NORTH EAST</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph B Grant</u>		24a. REC'D BY REGISTRAR <u>North East, Md</u>	
24b. REGISTRAR'S SIGNATURE <u>DATE MAY 22 '59</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Grant</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

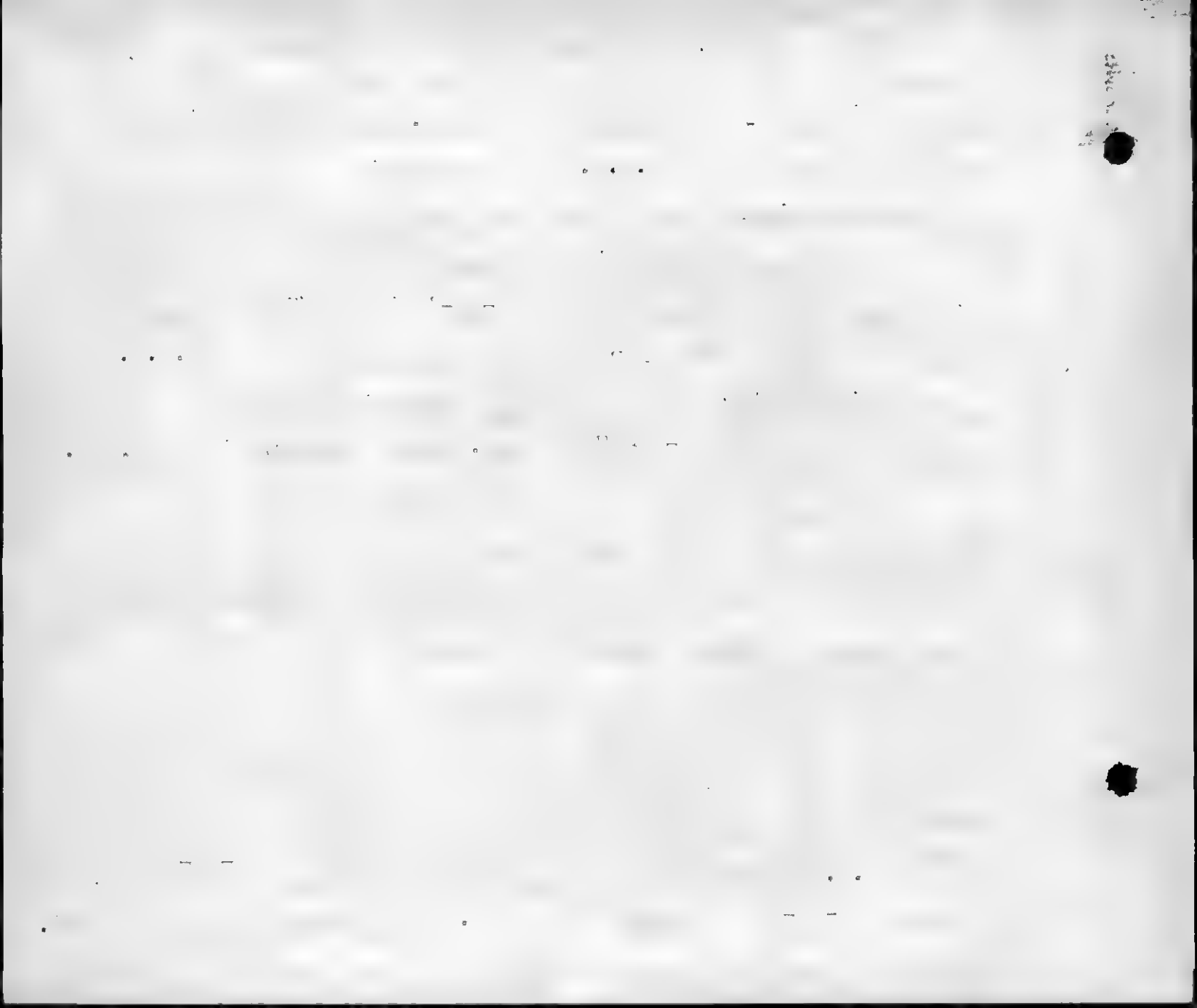
5518

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05525

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk Mills</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				e. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Franklin</b> Last <b>Rutter</b>				4. DATE OF DEATH Month <b>5</b> Day <b>22</b> Year <b>19 59</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-31-1901</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Parts</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chrysler Corp?</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Daniel Rutter</b>				14. MOTHER'S MARDEN NAME <b>Elizabeth Davis</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>211-07- 7244</b>		17. INFORMANT Address <b>Mrs. Anna M Rutter, Elk Mills, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>R. D. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <b>R. D. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-25-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cherry Hill Cecil Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				ADDRESS <b>ELKTON MD</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 26 '59</b>			
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

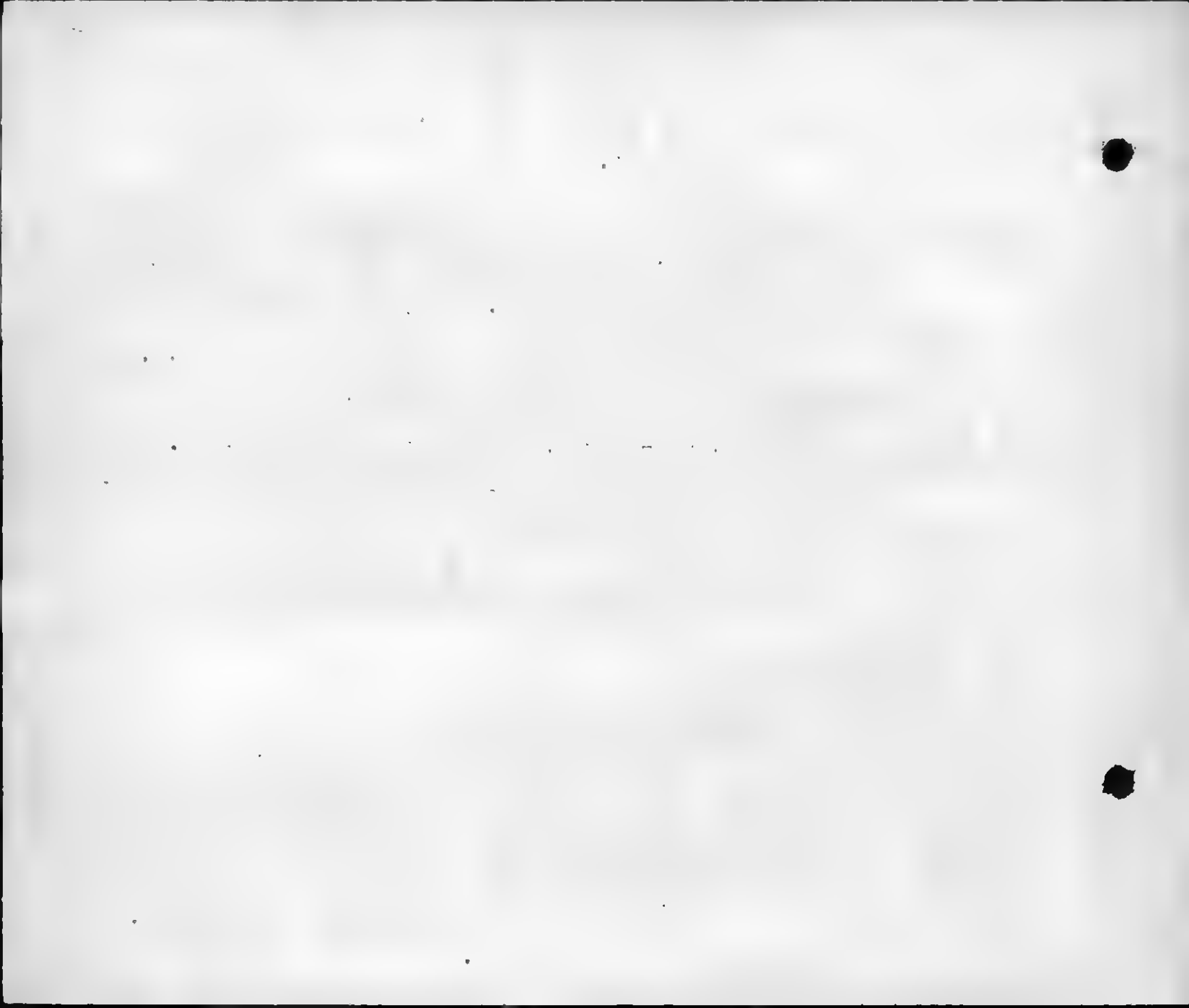
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5519 CERTIFICATE OF DEATH

Reg. Dist. No.

05526

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>70 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>416 North Street</b>				d. STREET ADDRESS <b>416 North Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEWIS</b> Middle <b>A.</b> Last <b>Seth</b>				4. DATE OF DEATH Month <b>5</b> Day <b>17</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1882</b>		9. AGE (In years lost birthday) <b>76</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Realtor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sales</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Seth</b>				14. MOTHER'S MAIDEN NAME <b>Lena Carr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-12-6789</b>		17. INFORMANT Address <b>W. Andrew Seth Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>U Remial Cochran Frailty</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-C.V.A.</b> DUE TO (c) <b>Diabetes Mellitus &amp; Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>2 mcs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>29 March, 1959</b> , to <b>17 May, 1959</b> , that I last saw the deceased alive on <b>5/17/59</b> , 19, and that death occurred at <b>2:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George J. Kries</b> M.D.				ADDRESS (Street, city or town, state) <b>Elkton, Md.</b>			
PHYSICIAN'S NAME (Type) <b>George J. Kries</b>				DATE SIGNED <b>5/19/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 21, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

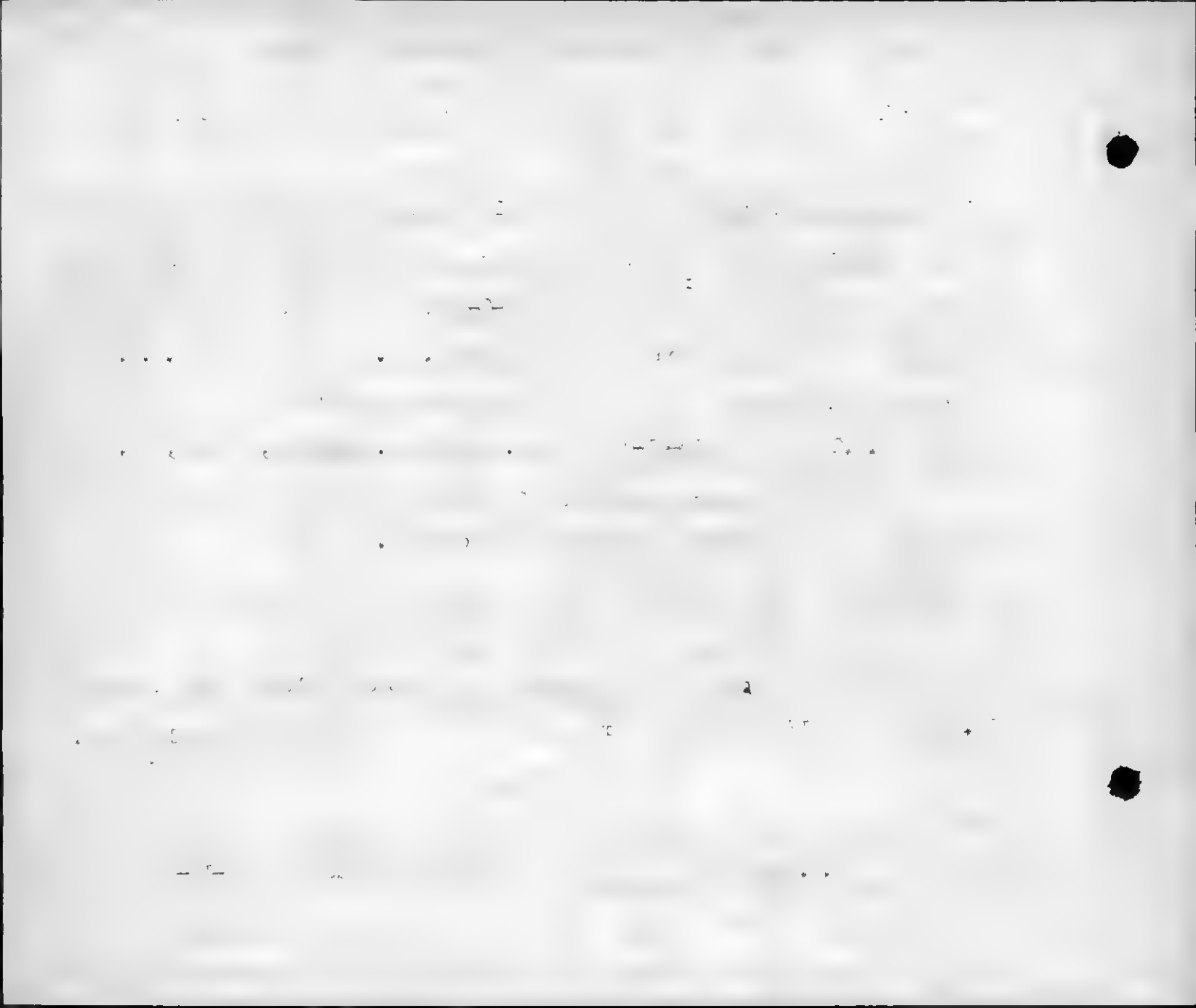
Reg. Dist. No.

05527

5520

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>182 Hollingsworth Manor</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> d. STREET ADDRESS <u>182 Hollingsworth Manor</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Milford Ayres Simmons</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>5 17 1959</u>		<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>2-2-1907</u>		<b>9. AGE</b> (In years last birthday) <u>52</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bar Tender</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Saloon</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Elkton, Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>																	
<b>13. FATHER'S NAME</b> <u>John Wesley Simmons</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Elizabeth Sick</u>																	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>N.W.2</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-01-1590</u>		<b>17. INFORMANT</b> <u>Mrs. Milford A. Simmons, Elkton, Md.</u>																	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Perforating bullet 25 caliber wound in right temple</u> DUE TO (b) <u>and made exit left side of head.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> _____						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with 25 caliber automatic revolver in the right temple</u>																			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>10-25 5 17 19 59</u>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Elkton</u> (County) <u>Cecil</u> (State) <u>Md.</u>															
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																					
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u> <b>EXAMINER'S NAME (Type)</b> <u>R.C. Dodson</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>5-27-59</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>5/20/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ELKTON CEMETERY</u>		<b>22d. LOCATION (City, town, or county)</b> <u>ELKTON, Md.</u> (State)															
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>TIPPIN FUNERAL HOME - 2nd Ave. 2nd Fl. Md.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>MAY 21 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>															

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





5536

## CERTIFICATE OF DEATH

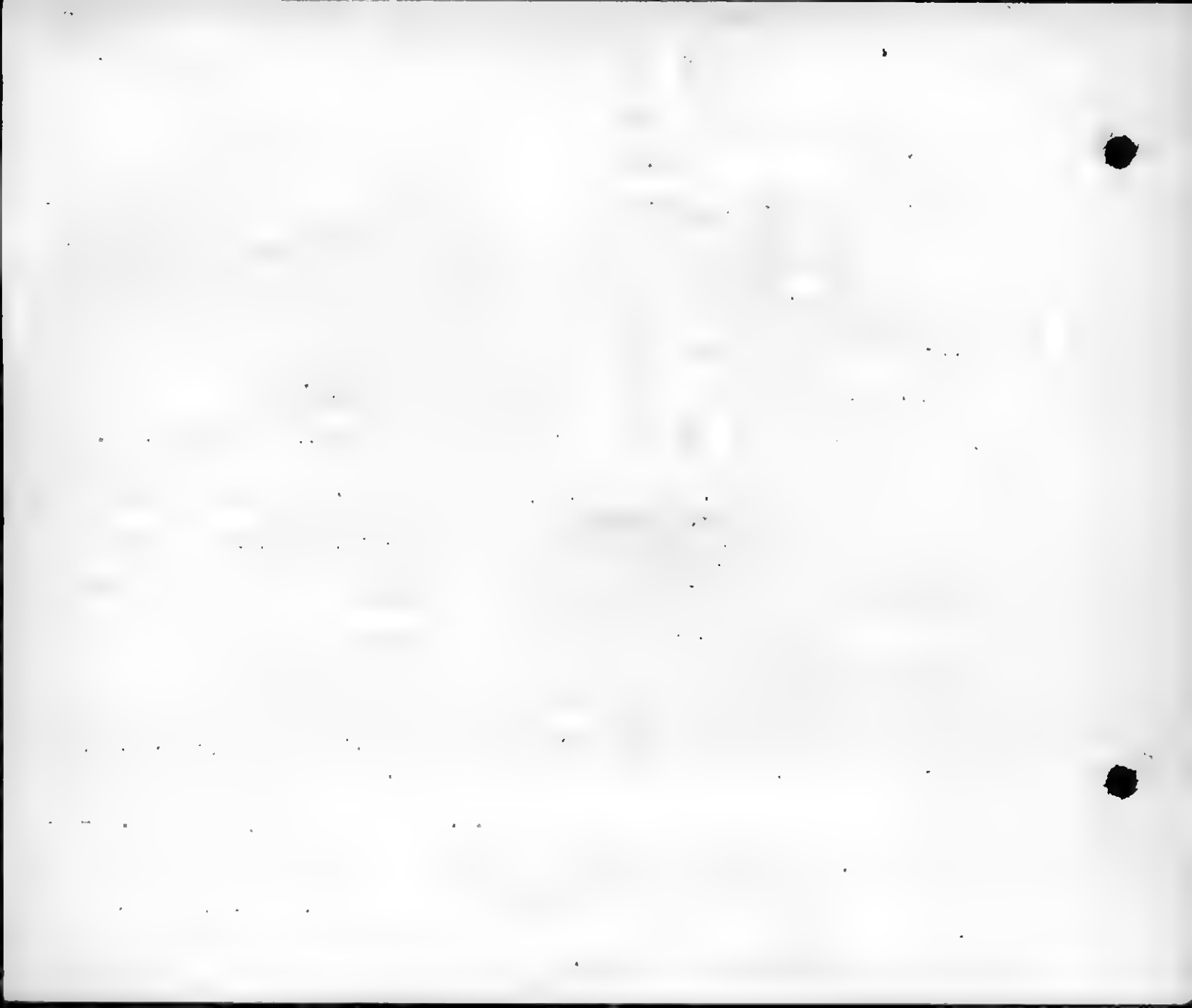
Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN lb <b>2mos.6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre DeGrace</b> d. STREET ADDRESS <b>300 Bourbon</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROLAND</b> Middle <b>A.</b> Last <b>TYSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-2-90</b>
9. AGE (In years last birthday) <b>68</b>		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>	11. IF UNDER 24 HRS Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES TYSON</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH HUMPHREY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records, VAH., Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia acute &amp; chronic with pul- Several weeks</b> DUE TO <b>monary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease with marked unknown</b> DUE TO <b>coronary sclerosis</b> (c) <b>Primary carcinoma of lung unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary fibrosis &amp; emphysema</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a m. <b>19</b> p m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 23, 1959</b> to <b>May 29, 1959</b> , and that death occurred at <b>3:25 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>5-29-59</b>			
ACTUAL SIGNATURE <b>B. S. LINN</b>		PHYSICIAN'S NAME (Type) <b>B. S. LINN</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6/3/59</b>		22b. DATE THEREOF <b>6/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myer, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON, Havre DeGrace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05529

Reg. Dist. No. 96

5537

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. LENGTH OF STAY IN 1b <u>2 mo. 10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Burlington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>122 E. Pearl Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>RICHARD</u> Middle <u>(NMI)</u> Last <u>VANLEER</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>1</u> Year <u>19 59</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Negro</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Unknown</u>		<b>9. AGE</b> (In years last birthday) <u>65?</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>unknown</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u>			
<b>13. FATHER'S NAME</b> <u>Walter Vanleer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Robinson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT</b> Address <u>Hospital Records, VAH, Perry Point, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <u>Bronchopneumonia unresolved</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral hemorrhage right side, subdural</u>            DUE TO (c) _____         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH         </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>900.0</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down cellar steps.</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>9:00</u> <u>2-19, 59</u> P. M.		<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
<b>20f. (City or town)</b> <u>Burlington, New Jersey</u>		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>R. C. Dodson</u> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <u>R. C. DODSON</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>5-1-59</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>REMOVAL</u>		<b>22b. DATE THEREOF</b> <u>5/14/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Beverly National</u>			
<b>22d. LOCATION</b> (City, town, or county) <u>Beverly, New Jersey</u>		<b>(State)</b> _____					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Pennington &amp; Son</u>				<b>ADDRESS</b> <u>Havre de Grace, Md.</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>DATE MAY 7 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

5521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05530

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delaware</b>	
c. LENGTH OF STAY IN 1b <b>4 hurs</b>		d. STREET ADDRESS <b>107 Sunset Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James L. Vaughan</b>		4. DATE OF DEATH Month Day Year <b>5 23 19 59</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Efficiency Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dupont Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James H. Vaughan</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Layman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>none</b>		16. SOCIAL SECURITY NO. <b>146-09-6754</b>	
17. INFORMANT <b>James L. Vaughan, Jr.</b>		Address <b>Del. 107 Sunst Drive, De</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5-23-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-27-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery,</b>		22d. LOCATION (City, town, or county) (State) <b>nr. Chesapeake City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>		ADDRESS <b>North East</b>	
24a. REC'D BY REGISTRAR <b>DATE MAY 27 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

10-2-30

STATE OF NEW YORK  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, New York		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
Jan 1, 1930		10:00 AM		Home		Dr. Smith	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]		[Signature]	
Witness		Witness		Witness		Witness	
[Signature]		[Signature]		[Signature]		[Signature]	

5538  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>				c. LENGTH OF STAY IN 1b <b>10 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <b>Main</b>			
3. NAME OF DECEASED (Type or print) First <b>Stanley</b> Middle <b>Nartin</b> Last <b>Williams Sr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>15</b> Year <b>19 59</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 25, 1908</b>		9. AGE (In years lost birthday) yrs. <b>50</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DuPont Chestnut</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jesse C. Williams</b>				14. MOTHER'S MAIDEN NAME <b>Addie England</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT <b>Mabel Barr Williams North East, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>3 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 12, 1959</b> , to <b>May 14, 1959</b> , that I last saw the deceased alive on <b>May 14, 1959</b> , and that death occurred at <b>1205d</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence T. Benson</b> M.D.				ADDRESS (Street, city or town, state) <b>Port Deposit</b> DATE SIGNED <b>May 15, 1959</b>			
PHYSICIAN'S NAME (Type) <b>CLARENCE T. BENSON</b>				<b>Maryland</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hopewell</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit Rd Cecil Co., Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b> ADDRESS <b>Joseph R. Grant North East, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 20 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. M. S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John Doe		Jan 15, 1950	
Age		Sex	
65 years		Male	
Place of Birth		Cause of Death	
New York City		Heart Disease	
Occupation		Manner of Death	
Teacher		Natural	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Date of Certificate		Place of Death	
Jan 15, 1950		Home	
Name of Hospital		Name of Doctor	
None		None	
Name of Burial Place		Name of Cemetery	
None		None	
Name of Undertaker		Name of Funeral Home	
None		None	
Name of Coroner		Name of Medical Examiner	
None		None	
Name of Health Officer		Name of Registrar	
None		None	